MO HEALTHNET OVERSIGHT COMMITTEE MEETING

January 31, 2012
600 W. Main Street
Jefferson City, MO

MINUTES

Members in Attendance
Corinne Walentik
Timothy McBride
Mark Sanford
Joseph Pierle
Senator Rob Schaaf
Rep. Jeanne Kirkton
Rep. Keith Frederick
James McMillen
Margaret Benz
Gerard Grimaldi (via phone)
Kecia Leary (via phone)

Members in Attendance (cont'd)
Brian Kinkade
Margaret Donnelly
Joe Parks

Members Absent
Sen. Joseph Keaveny
Bridget McCandless
Ingrid Taylor
Carmen Parker Bradshaw

DSS Staff in Attendance
Ian McCaslin, MHD
Marga Hoelscher, MHD
Rhonda Driver, MHD
Karen Purdy, MHD
Samar Muzaffar, MHD
Brianna Bryant, MHD
Billie Waite, MHD
Diana Jones, MHD
Alyson Campbell, FSD
Emily Rowe, FSD
Jordan Humphreys, DLS

Others in Attendance
Leanne Peace, MO Kidney Program
Jim Burns, CMS
Ruth Ehresman, MO Budget Project
Berend Koops, Merck
Donnell Cox, DentaQuest
Ron Fitzwater, MO Pharmacy Assn.
Jaime Bodden, Sen. Lamping Ofc.
Jesse Favre, Sen. Lamping Ofc.
Rachel Mutrux, MO HIT
Joel Ferber, Legal Services of Eastern Missouri
Mary Beele Mann , Legal Services of Eastern Missouri
Steve Renne, MO Hospital Assn.
Melba Price, Price Consultants
Lana Baker, Lobbyist
Susan Henderson Moore, Polsinelli, Shughart
Zachart Bannert, Flotron & McIntosh
Sam Richardson, Molina
Jake Luebbering, OA Budget & Planning
Diane Twehous, Wipro
Kim Brandt, Wipro
Lovey Barnes, Molina
Pam Victor, HealthCare USA
Tina Gallagher, Molina
Kirsten Dunham, Paraquad

WELCOME/INTRODUCTIONS/MINUTES – Dr. Corinne Walentik, Chair, called the meeting to order at approximately 12:00 noon. Margaret Benz was introduced as the newest member of the Committee. Ms. Benz has been appointed to the nurse position and awaits confirmation of the full Senate. Minutes of the November 15, 2011 meeting were approved as submitted.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY– Summarizing the handout, Emily Rowe, Family Support Division, reported that participants as of December 2011 totaled 893,535. The chart reflected that of the 893,535, 60.4% are children, 18.8% are persons with disabilities; 9.0% custodial parents, 8.7% seniors defined as individuals 65 or older; and 3.1% are pregnant women. Of the 539,975 children, 71,438 are receiving services through the Children's Health Insurance Program.

In addition, 63,676 women are receiving services through the Women's Health Services program. This category is reported separately as benefits for this group of eligibles are limited to family planning services, not the full MO HealthNet benefit. A higher federal match is received for these services.

BUDGET UPDATE – Speaking from a powerpoint, Marga Hoelscher, Deputy Director, MO HealthNet Division, provided an overview of general revenue growth rates. Estimated growth rate for FY 2013 (July 2012 – June 2013) is 3.9%, compared to 2.7% for FY 2012. Of note, FY 2013 is the final year of the phase out of federal stabilization funds. The consensus revenue estimate for FY 2013 is $7.585 billion which is $285 million above the revised FY12 consensus revenue estimate, yet $400 million below FY 2008 actual collections. Sources of general revenue were outlined, i.e., sales and use tax, corporate income/franchise tax; individual income tax, and other sources.

The Governor's recommended operating budget for FY 2013 totals $22.9 billion. Sources of funding include general revenue of $8 billion, federal funds of $7.3 billion, and $7.6 billion in other funds. A breakdown of the Governor's recommended funding was reviewed, which includes $2.43 billion (30.3%) for human services.

An overview of budget balancing reductions was provided, including $191.7 million for Medicaid savings. No cuts for eligibility or covered services were included. The savings were achieved through efficiencies and cash balances, such as rate development efficiencies in new contracts; savings from brand to generic psychotropic drugs; savings in pharmacy rebate as a result of managed care carveout and additional rebates from hospital billings. Details of the savings by category were provided.

Committee members questioned the managed care and home and community based services savings outlined in the presentation. It was shared that savings in the managed care program were achieved through enhanced care delivery program efficiencies such as avoidable/preventable hospitalizations and action plans for case management for high risk women. These efficiencies were always part of the managed care program, but are now built into contract requirements. With the collaboration of the health plans, the state is working to bend the trend of managed care spending. The managed care program does not impact services to the elderly or disabled populations. The home and community based services savings will not impact patients. The savings booked were the result of the change in federal match rate from 63% to 65% for the Balancing Incentive Program (BIP).

Proposed Medicaid funding across all agencies was identified:

Elementary and Secondary Education – $3,945,254
Mental Health – $893,850,535
Health and Senior Services -- $633,776,746
Social Services -- $6,857,986,262
Total Proposed Medicaid Funding -- $8,389,558,797

FY 2013 new decision items were outlined. An increase in caseload growth is not projected in FY 2013.

MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) -- Donna Checkett, MACPAC Commissioner, explained that MACPAC was established in the Children's Health Insurance Program Reauthorization Act of 2009 and later expanded and funded through the Patient Protection and Affordable Care Act. MACPAC is comprised of 17 independent commissioners with a broad range of expertise who are appointed for staggered three-year terms by the Comptroller General of the United States. Similar to the Medicare Payment Advisory Commission (MedPAC), an independent agency established to advise Congress

on issues affecting the Medicare program, MACPAC's scope is to review Medicaid and Children's Health Insurance Program (CHIP) payment and access policies and make recommendations to Congress. Sample areas of focus include access, payments, policies and relationship of policies to eligibility, enrollment, coverage, health care delivery, and interactions with Medicare. While statute provides that MedPAC is lead for issues regarding dual eligibles, the two commissions do collaborate on common issues.

MACPAC conducts open meetings through the year during which open comments are accepted. While they choose their projects, ideas are received from Congress, and Congressional staff are invited to the meetings to gain perspective. MACPAC has the ability to request data from federal offices, but Ms. Checkett expressed that due to the differences in state Medicaid programs, it is difficult to obtain good data and there is little data on managed care.

Ms. Checkett encouraged individuals to utilize the resources available on the MACPAC website at http://www.macpac.gov/. Reports and statistics are available on topics such as CHIP financing, Medicaid fee-for-service provider payment process, and evolution of managed care. MACPAC currently has four projects underway on the topics of Medicaid only eligibles with disabilities; program integrity, measuring access to care and services; and financing and funding of Medicaid.

In response to questions from MO HealthNet Oversight Committee members, Ms. Checkett offered that MACPAC works with the National Association of Medicaid Directors to gain state input on federal policy recommendations. Input is also sought through State Medicaid representatives and gained through the expertise of Commission members. A possible solution for the managed care data issue is not readily available, but is something that the Centers for Medicare and Medicaid Services (CMS) is looking at. MACPAC's focus on review of managed care is more than controlling costs; it is on the call centers, case management, and administrative duties that managed care brings to the Medicaid program. A definition of access is included in an early report, available on the website.

SPENDDOWN DOCUMENTATION – Alyson Campbell, Family Support Division, updated the Committee on progress on the spenddown documentation issue discussed at the November meeting. Two meetings of a stakeholder committee, comprised of providers, advocates, and other interested parties, have been held. The December meeting was an information exchange during which the concerns of the group were shared. The focus of the January meeting was to begin exploring other options for participants to meet spenddown if it could not be met under paying in or incurred expenses. A smaller workgroup was formed and met on January 30, 2012 to work through options. This smaller workgroup will report to the stakeholder committee. One option in early stages of research is a prospective model for individuals with routine on-going treatment regiments that are predictable, known, and the information is available on monthly basis. This option would require the provider to voluntarily agree to establish a receivable in the amount of spenddown which could then make the individual eligible for services the first day of the month; the provider would then bill the individual. CMS approval would be required to implement.

Within the Family Support Division are 1700 eligibility specialists across the state. In addition to determining Medicaid spenddown, these specialists determine eligibility for TANF and food stamps. To better manage spenddown caseload, a group of eligibility specialists have been identified as experts in management of spenddown cases. Policy has been clarified on how to process spenddown, and these staff have completed extensive training on the application of those policies. An expert is located in each county office. The list was requested by the Committee.

The instituted pause of spenddown is continuing for current participants. Beginning in February the specialists will contact each of the approximately 6800 individuals who currently meet their spenddown through incurred expenses. The process will be reviewed with each participant to ensure all expenses are being reported and determine if the individual might be eligible under another program that would remove the spenddown requirement. The pause will end May 1, 2012. As a result of a question from the Committee it was indicated that participants will receive written follow-up to the phone call. The Committee requested a copy of the information.

The spenddown policy is set in federal and state statute and regulation. Policy direction is given to staff to apply to individual cases. Due to a statement missing from an example, an inconsistency in application of treatment of third party payers occurred. Family Support Division is aware of 65 patients who have questionable participation because of these issues. Nursing home residents were not affected.

A number of conversations have been held with CMS at both the regional and central office levels. Other states struggle with third party payer issues and there is not a clear best model. CMS has messaged to take care of the participants; language and paperwork is secondary to patient care. Official written communication from CMS is expected.

Public comment was taken during the discussion. Leanne Peace, Missouri Kidney Program, appreciates the pause and the ability to provide input. Concern was expressed that Washington County is not following the pause. With respect to phone calls with affected individuals, she expressed that it may be hard for some individuals to understand the issues over the phone. Ms. Peace indicated a May end date for the pause is perhaps ambitious and suggested delay until other workgroup suggestions are explored. Given that many affected individuals cannot live independently in the home, they are at risk for nursing home placement if the issue is not resolved. Ms. Peace believes there are other individuals directly affected than the 65 patients noted. She was asked to relay information to Anna Beckett with the Family Support Division, to include any transplant effect.

Kirsten Dunham, Paraquad, indicated that three clients at Paraquad lost personal care as a result of the issue; an estimated 25 participants could be affected. Names of others were not shared because of the pause. She suggested not making any changes until all options have been considered and the best solution possible reached. It should be applied to all individuals, including new eligibles.

Joel Ferber, Legal Services of Eastern Missouri, asserted that this is a change in policy that negatively impacts people and requires a rule. He indicated less restrictive policies in an old manual were not illegal and have been deleted. Mr. Ferber also shared concern that Washington County is not abiding by the moratorium. While food and shelter is included for nursing home residents, the cost of dialysis is in addition to the nursing home cost. It is important to find a way to keep dialysis patients in the community. Concern regarding the training received by the eligibility workers designated spenddown specialists was also relayed, specifically with the differences between Medicaid and Medicare. He suggested it is not a good idea to estimate what Medicare will pay. Mr. Ferber also questioned the state's ability to contact the 6800 people by phone. He urged the state not to make any changes until the impact on participants is known, CMS guidance is received, and a rule is filed.

Dr. Walentik requested another update at the April meeting.

HITECH: RESOURCES FOR EHR ADOPTION AND USE – Diana Jones, MO HealthNet Division, described the incentive payments available through Medicare and/or Medicaid to support certain hospitals and

professionals in adopting certified electronic health record (EHR)technology. High level differences between the Medicare and Medicaid EHR programs were outlined in the powerpoint presentation. Providers eligible for the programs were reviewed. Eligible professionals, i.e., doctors, nurse practitioners, certified nurse midwives, dentists, certain physician assistants, must choose to participate in either the Medicare or Medicaid incentive program. Hospitals, however, can qualify for both Medicare and Medicaid incentives. Provider technical support for selecting and implementing EHRs is received from extension centers.

Registration with the Centers for Medicare and Medicaid Services (CMS) is required in order to apply for Missouri's EHR Medicaid Incentive Program. Attestation information is submitted via a secure portal. As of January 26, 2012, 1,520 professionals and hospitals have registered with CMS to apply for Missouri's program. Of that total, 1,118 have registered on Missouri's portal. Deadline for applications for professionals applying for calendar year 2011 is February 29, 2012. Providers not meeting this deadline can apply for 2012.

During the time period July 2011 – January 2012, $38,193,352 in incentive payments were paid. Of that amount, 33 hospitals received payments totaling $32,972,935 and 246 payments were made to professionals, totaling $5,220,417.

Details on the methodology for hospitals to meet the Medicaid volume threshold was requested. It is defined as the ratio with the numerator of discharges paid for by Medicaid, either in whole or in part including Medicaid managed care, during a representative 90-day period in the previous year and denominator of all discharges (including those paid for Medicaid) for the same time period.

In response to questions from Committee members it was noted that the list of approximately 1500 certified EHR technology products and components is available on the Office of the National Coordinator (ONC) website at http://healthit.hhs.gov/portal/server.pt?open=512&objID=2884&parentname=CommunityPage&parentid=357&mode=2&in_hi_userid=12059&cached=true. Group discussed the process for EHR products to be certified by the Office of National Coordinator. There is no state accreditation; the state does not determine certified vendors or products.

The Missouri Health Information Technology (MO HIT) Assistance Center is Missouri's federally-designated regional extension center. It is funded through an award from the ONC. Representing the MO HIT Assistance Center, Rachel Mutrux shared their role is to help providers choose and implement a certified EHR system and help eligible providers meet the Medicare or Medicaid criteria for incentive payments. Provider groups served include both hospitals and professionals. In adopting an EHR system, financial, technical, and organization change challenges are faced. The Extension Center offers services to assist providers in these challenges. Information of educational webinars was shared. Ms. Mutrux also outlined providers by region and the status of meeting meaningful use.

Question was posed if the MO HIT Assistance Center provides data in terms of user interface in helping hospitals select an EHR system. Ms. Mutrux indicated that prior to their hospital contract award, a RFI process had been started. Primary care data received as the result of the RFI was reviewed and evaluated. When the hospital contract was awarded, most hospitals had already purchased an EHR system. The Assistance Center does not endorse any one product, but maintains a list of 12 different products they would recommend based on their research. The criteria was requested by the Committee.

There is concern by hospitals that if they change EHR products meaningful use would be lost and, as a result, the incentive payment. Ms. Mutrux indicated that the MO HIT Assistance Center is aware of that situation and can assist by serving as an intermediary between the hospital and vendor. Participating hospitals are eligible for funding for several years. A hospital that changes systems might miss one year of the incentive payment, but it can be picked up the next year.

AFFORDABLE CARE ACT – While not an agenda item, Dr. Walentik requested an update on funding to replace the current eligibility and enrollment system. Dr. McCaslin indicated that the state is currently in the early phases of the legislative appropriation process. The system need has been communicated with the General Assembly. Current state of affairs is to engage the appropriations process to the feasibility of using available funding through the implementation grant; however, appropriation authority is needed. Estimated cost to completely replace the system is $120-130 million. While the existing system is old, it is functional. As discussed in an earlier meeting, consultants were clear that the existing system will not be compliant with new requirements.

ADJOURN – Before adjourning at 3:15 pm, Dr. Walentik encouraged Committee members to submit suggested agenda items to her, Ian McCaslin, or Karen Purdy. Next meeting is April 10, 2012.